Position Paper:

Cannabis Legalization and the Ontario Personal Support Worker: Reconciling OHSA with Involuntary Consumption of THC in a Home-Care Setting

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Introduction

On October 17th the Canadian government made the recreational use of Cannabis legal. As Canadian society adjusts, Personal Support Workers in Ontario, more specifically those in private home care, will encounter a new dilemma- clients in their care opting to use Cannabis in their homes. This places an entirely new range of concerns on the backs of PSWs and by extension the OPSWA. As this topic is new to Canada and new to Health Care in North America, it is important that the OPSWA takes an active role in formulating any new policies and guidelines associated with how the legalization of recreational cannabis impacts the PSWs working in private home care either independently or employed by a home care agency.

This paper will not focus on the health and safety concerns associated with the use of recreational cannabis by residents of long term care facilities, hospitals or group homes as best practice dictates that these institutions have adequate policies and procedures in place to protect both the residents and their respective PSWs.

This paper will focus on identifying challenges and concerns recently raised by our members and stakeholders including: the chemical characteristics of cannabis and their effects, the delivery methods and their effects and finally, the risk of involuntary consumption on the PSW in the home care setting.

Challenges

As it stands now, many employees in Ontario have the right to refuse work if that employee feels that the work may be a danger to their health and safety under the Ontario Occupational Health and Safety Act R.S.O 1990, Part V Sec 43. (2)(d)(ii). As a consequence generally a PSW cannot refuse unsafe work, even if they are working in a private home setting as per this section.

The introduction of recreational cannabis, however, introduces new challenges that The OPSWA must acknowledge. From a professional association standpoint we feel that this issue further disturbs the already delicate balance of rights between the Personal Support Worker and the client(s) they serve. This issue in turn raises a host of other questions such as; how is a fair balance of rights achieved and protected in private care homes where a person needing care chooses to exercise their new right to use cannabis? What happens if the Personal Support Worker inadvertently consumes second hand cannabinoid air particulates and, after the shift, is required to operate a motor vehicle while involuntarily under the influence? What are the insurance implications? The possible risk to third parties?
Cannabis: THC and CBD

Before we can answer these question one must first understand the specifics of what the chemical compounds are and how these compounds are understood to impact with the user. According to the Centre for Addiction and Mental Health:

“Cannabis is a product of the cannabis sativa plant that is used for its psychoactive and therapeutic effects. It comes in many forms, including as dried flowers and leaves; hash; extracts, such as oil (e.g., honey oil, phoenix tears) and shatter; and edibles (e.g., candies, butter or baked goods).

Cannabis contains hundreds of chemical substances. More than 100 chemicals, called cannabinoids, have been identified as specific to the cannabis plant. THC (delta-9-tetrahydrocannabinol) is the main psychoactive cannabinoid and is most responsible for the “high” associated with cannabis use. Another cannabinoid is cannabidiol (CBD). CBD has little or no psychoactive effects, so you do not feel high. CBD counteracts some of the negative effects of THC.”

This definition from the CAMH offers us a clear and concise breakdown of the different chemical compounds and how those compounds impact the user. Most importantly this allows the association to focus its attention solely on addressing the possibility of involuntary consumption of the chemical compound delta-9-tetrahydrocannabinol (THC) rather than that of cannabidiol (CBD) since the psychoactive properties are restricted to the former. It is the opinion of the OPSWA Human Resources Department that the benign effects of the chemical compound cannabidiol negates any need to address involuntary consumption concerns from an occupational health and safety perspective.

While the definition provided by the CAMH clearly defines the difference between the two chemical compounds it does not clearly address the range of methods in which this compound can be consumed. As it currently stands neither the Canadian Department of Justice, nor the Government of Ontario have any restrictions on the method(s) of cannabis consumption.

Understanding Delivery Methods and Involuntary Consumption

According to the California Cannabis Industry Association (CAIA), consumption of cannabis is generally divided into seven different methods and include smoking, vaping, edibles, tinctures, topical solutions, full spectrum oil and dabbing. This lack of any preferred or uniform consumption model increases the

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1 CAMH https://www.camh.ca/en/health-info/mental-illness-and-addiction-index/cannabis
2 Involuntary Consumption occurs when registered members of the Ontario Personal Support Workers Association involuntarily consume the active delta-9-tetrahydrocannabinol.
3 For further reading on the effects of the chemical compound cannabidiol, its properties please consult: Grinspoon, Peter MD “Cannabidiol (CBD) –what we know and what we don’t” August 2018 Harvard Health Publishing, Harvard Medical School https://www.health.harvard.edu/blog/cannabidiol-cbd-what-we-know-and-what-we-dont-2018082414475
4 World Health Organization
5 https://www.justice.gc.ca/eng/cj-jp/cannabis/
6 https://www.ontario.ca/page/cannabis-legalization
7 https://www.cacannabisindustry.org/ - under resources www.SafeCannabisUse.com
risk of involuntary consumption by PSW in a home care setting due simply to the variations open to deliver the THC compound into the bloodstream.

Despite a lack of any uniform delivery method, a review of the CAIA website offers clear descriptions including information on health effects and allows the association to further focus on the delivery methods felt to pose the greatest risk of involuntary consumption and further allows for classification into delivery methods that pose the greatest risk to a PSW. These classifications are defined as being in Group “A” – those with the greatest risk of involuntary consumption for a PSW and Group “B” – those that are not considered a risk.

For the benefit of this position paper the OPSWA Department of Human Resources identifies the following THC consumption methods as falling under Group “A”: dabbing, smoking, edibles, topical solutions. Smoking and dabbing were identified as being the most likely to either introduce THC particulates into the air and have the smallest onset time for individuals impacted, the combination of which may quickly lead to involuntary consumption by the PSW. Edibles and topical solutions, if not properly identified and stored, may lead to involuntary consumption through happenstance and therefore must be placed in this category.

Conversely OPSWA designates the following as Group “B”: vaping, tinctures, full spectrum oil. These THC delivery methods have a low likelihood of involuntary ingestion as the delivery methods require an electronic component (vaping) which has no carcinogenic by products or direct oral ingestion using a syringe (tinctures and oils). It is the opinion the necessary steps needed to ingest the THC ingredient directly reduces the risk of involuntary ingestion.

Conclusion

It is the opinion of the OPSWA that since the effect of involuntary consumption remains as a yet unknown, any our members who feel that that their health and judgement may be impaired due to the involuntary consumption of THC particulates, have the right to refuse work in that setting. Should the member find themselves in this situation the OPSWA supports the individual choice of our members to separate themselves from that situation so long as the absence is not sudden as to place the person for whom they care in immediate danger.
OPSWA Members and Cannabis Use

The OPSWA firmly acknowledges the right for its members to choose to or not use cannabis for reasons of recreation, so long as the member is not under the influence of THC:

- while on duty,
- while operating a motor vehicle,
- while in transit to and from their client.
- While attending any OPSWA or professional functions
- While representing the OPSWA

As cannabis use becomes more normalized in Ontario the OSPWA knows that PSWs will face situations relating to cannabis use that have yet to be anticipated as a result we encourage our members to dialogue with us on any concerns regarding this new issue in health care.

The Ontario Personal Support Workers Association

OPSWA is the Professional Association for PSWs in Ontario, bringing Standards and Recognition to the vocation every day. OPSWA is a not for profit incorporated legal association and the only one of its kind in the world, bringing together over 33,000 fully verified Personal Support Workers since conception in 2010. Our goal is to transform the PSW into a profession of choice in the Health Care field.

OPSWA’s Mission Statement

To continuously strive to improve the professional status of the Personal Support Workers of Ontario through advocacy for excellence and consistency in training, services, working conditions, and value to those we serve.

Vision - Standardization of the Personal Support Worker will afford all Ontarians the quality of care which they are entitled to.